Reuben I Thaker MD PLLC dba Phaze Laser Med Spa, dba Thaker Cosmetic and Wellness

Informed Consent for Treatment

I, _____consent to and authorize Reuben I Thaker MD PLLC, dba Phaze Laser Med Spa ('Company') to perform multiple treatments, whether of a medically necessary or entirely cosmetic nature, laser procedures and or other services, and further including but not limited to anything which may be handwritten herein _____. Treatments or procedures if any may use laser, light, water pressure, mechanical needling or abrading, chemical, medications, surgical procedures, energy based and or other technology.

If procedure is cosmetic in nature then it is not a medically necessary. Further, becoming a cosmetic procedure client of Company, does not constitute treatment of any medically necessary condition, nor a physician-patient relationship with Company, its medical staff or its agents. Further, you are aware that many procedures, applications or treatments in medical or cosmetic usage are not FDA approved and considered 'off label' use. This is particularly so for cosmetic purposes, and you agree to such usage.

Any treatment plan depends on your participation at all times and providing our staff and doctors with full and accurate information. You further understand, that no guarantee of results, cosmetic or otherwise, has been offered or implied.

As a patient you have the right to be informed about your treatment if any so that you may make the decision whether to proceed for your treatments and or procedure(s) or decline after knowing the risks involved. This disclosure is to inform you about the risks, benefits, alternatives, side effects and possible complications related to procedure indicated above:

The following problems may occur with laser, chemical, surgical, medical or other systems or treatments.

1. **The possible risks of the procedure include but are not limited to** pain, swelling, redness, bruising, bleeding, infection, blistering, crusting/scab formation, ingrown hairs, infection, and unforeseen complications which can last up to many months, years or permanently, worsening or no change in the problem of concern or incomplete resolution of the problem.
2. **There is a risk of scarring.** Scarring or other textural changes to skin happens uncommonly and can be permanent.
3. **Short term effects may include reddening, mild burning, temporary bruising or blistering.** A brownish/red darkening of skin (**'hyperpigmention'**) or lightening of skin (**'hypopigmentation'**) may occur even months or years later, and or permanently following treatment. Loss of freckles or pigmented lesions can occur.
4. **Pain:** methods to minimize pain are offered though no procedure to be considered painless.
5. **Infection:** infection following treatment is unusual, but can occur. If so added treatments or antibiotics may be necessary.
6. **Bleeding:** more than pinpoint bleeding is rare but can occur. Follow after-care instructions to minimize this and other risk.
7. **Allergic Reactions:** Pigments in tattoos or other substances in or on skin can induce a severe allergic reaction that can occur with each successive treatment, whether medical, cosmetic, laser, or other treatment.
8. I understand exposure to laser light could harm eyes. I will wear issued eye protection during all applicable treatment.
9. I understand providing full and accurate past medical history, including procedures related history, is vital to a good result. Compliance with the aftercare guidelines is crucial for healing, prevention of scarring, infection, and pigmentation changes.
10. I agree that no guarantee of results has been made. Most cosmetic problems can be improved, and this may require many treatments. There is a risk of death, severe bleeding or infection, or total failure of the treatment with any medical procedure, cosmetic or otherwise. While these risks can be unpredictable, these risks are very low and if any of these risk are substantial, you may be declined this or any services. Treatment of complications may cause other costs to you.

We often take photos or videos before, during or after treatment to document, assess, communicate, promote, train, or otherwise regarding our services. These may be at our discretion published in advertising, promotional or educational materials, or otherwise used and you expressly authorize us to do so. These will be anonymous but include age, sex, treatment details and not name unnecessarily otherwise identify you. You further agree this is within the allowed uses of our HIPAA notice of privacy practices, incorporated herein by reference.

ACKNOWLEDGMENT:

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and treatment and accept the risks. I hereby release Reuben I Thaker MD PLLC, dba Phaze Laser Med Spa ('Company'), its staff, and medical director from all liabilities associated with the above indicated procedure.

Patient Name:_____Sign:_____Date:_____
Patient or legal representative

Reuben I Thaker MD PLLC dba Phaze Laser Med Spa, dba Thaker Cosmetic and Wellness

Consent for Treatment and Authorization of Payment

CONSENT FOR TREATMENT

I authorize and consent to the administration and performance of all services and treatments, that may be ordered and or performed by Reuben I Thaker MD PLLC physician or non-physician personnel. Regarding services, cosmetic, esthetic, medical or otherwise, individual results may vary. No guarantee of results has been made or implied. Minors must be accompanied by parent/legal guardian, except for specific services for which parental consent or accompaniment is not required, per State Law or applicable Law.

ASSIGNMENT OF BENEFITS FOR MEDICAL SERVICES

In consideration of these medical services, I hereby assign, transfer and set over to Reuben I Thaker MD PLLC, all my rights, title and interest to medical reimbursement benefits under my health insurance policy (s). If my insurance benefits are provided through an ERISA plan (Employment Retirement Income Security Act) I hereby assign, transfer, and set over all my rights, title and interest as beneficiary of ERISA plan to Reuben I Thaker MD PLLC, regarding applicable treatment by Reuben I Thaker MD PLLC and or staff.

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION FOR PAYMENT

I authorize Reuben I Thaker MD PLLC to release medical information or copies from my medical record within a reasonable time frame to insurance companies, third party payers, or authorized agents, or other parties reasonably related and necessary for payment of services; or claims review organizations in order to process a claim for payment on my behalf. This information may be disseminated to any and all employer's insurance companies or their designee who may provide coverage for medical charges and to comply with the requirements of any Professional Review Organization. This authorization may be revoked in writing at any time.

PAYMENT AGREEMENT

All sales final. I hereby assume full responsibility for and agree to pay all costs, charges, and expenses incurred by the patient, to Reuben I Thaker MD PLLC dba Phaze Laser Med Spa. I understand and agree that this constitutes a direct primary and personal undertaking by me and is not conditioned or contingent upon payment of any such costs, charges or expenses by any third party. And assignment of benefits of any insurance policy or medical reimbursement plan shall not be deemed waiver of Reuben I Thaker MD PLLC's right to require payment directly from the undersigned. Reuben I Thaker MD PLLC expressly reserves its right to require such payment. In the event that this obligation remains unpaid, the undersigned agrees to pay all costs of collection, including, but not limited to reasonable attorney's fees. If the undersigned is more than one person, every obligation hereunder shall be joint and several.

Payment is due at the time of service. This may include deductible, copay, coinsurance, non-covered service payment, or other payment. This requirement shall be enforced, unless contravened by requirement of a government payor. Medicare and other insurances requires conscientious effort by the Practice to collect fees owed to Practice by the patient. See also, registration form.

For services to private pay patients, payment in full is due upon service. Our charges are usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of rates, unless we have a participating agreement with them. We will provide a receipt to you, that you may submit to your insurer, which may or may not pay in part for our services.

Credit Card Information

Credit Card Type _____ #_____ Exp_____/_____
Name as on card_____ 3 digit code_____
Cardholder's Billing Address_____ZIP_____

My signature below indicates authorization to process this credit card for charges at time of service, for the duration of my tenure as a patient or client of Reuben I Thaker MD PLLC, dba Phaze Laser Med Spa, including cosmetic services (non-medically necessary, non-insurance covered); and or private pay medical services; and or insurance-covered medical services such as for copayments, coinsurance, deductible; and for appointment cancellation charges . You agree we retain your credit card information to process future charges if any. Cosmetic service payment is due in full prior to service and is not covered by insurances. Further, all sales final. Practice follows applicable insurances billing policies if any, for medically necessary services. Further, I am financially responsible for any charges of any kind not covered by insurances. For private pay patients, payment in full is due before service. By signing I further acknowledge and consent to sections specifically indicated above: Consent for Treatment, Assignment of Benefits, Authorization to Disclose Medical Information for Payment and Payment agreement. I have received the Notice of Privacy Practices, incorporated into this Consent by this reference.

Cardholder Signature:_____ Date:_____

Reuben I Thaker MD PLLC dba Phaze Laser Med Spa, dba Thaker Cosmetic and Wellness

PERSONAL & MEDICAL HISTORY

PERSONAL HISTORY Please provide complete and accurate information.

Name _____ Today's Date _____ Date of Birth_____Age___
Phone (___) _____ Email_____Occupation_____
Home Address_____ City_____ State____Zip _____

Emergency Contact Name and Phone_____

Circle how you heard about us: Internet Search Term: _____ Facebook Instagram Yelp Youtube billboard magazine REFERRAL: _____

MEDICAL HISTORY

❑Yes ❑ No Are you currently under the care of a physician, dermatologist, PCP or other? If so, who and for what:_____

_____.

❑Yes ❑No Have you ever had a previous laser or other cosmetic surgery or procedure, if so which? _____procedure/date

_____procedure/date,_____procedure/date,_____procedure/date.

❑Yes ❑No Have you ever had unsatisfactory results from any medical professional, medical spa, laser treatment, or cosmetic services, describe:

_____.

Circle your skin type:	I	Always burns, never tans	IV	Rarely burns, always tans
	II	Always burns, sometimes tans	V	Brown, moderately pigmented skin
	III	Sometimes burns, always tans	VI	Black skin

Do you have any of the following medical conditions? (Please mark and then verbally describe all that apply)

❑Cancer ❑Diabetes ❑HIV/AIDS/Hepatitis B/C ❑Herpes ❑Arthritis ❑Frequent cold sores ❑Any active infection ❑Accutane use

❑History of raised or keloid scars ❑Skin cancer/lesions/disease ❑Sunburn or tanning in last 2 weeks ❑Darkening / lightening of skin after trauma

❑Blood clots, bleeding or other disorder ❑Implanted medical device/pacemaker ❑Heart attack or stroke ❑Any heart or lung disease or asthma

❑Anxiety or any psychiatric condition ❑Recreational drug use [includes marijuana or alcoholism] ❑Seizures

❑Pregnant or attempting pregnancy ❑Breastfeeding ❑Personal or family history of unusual reaction to anesthesia

❑ For tattoos: age of tattoo and if professional/homemade: _____.

❑Any other condition for us to consider , list AND verbally describe to us:_____.

MEDICATIONS

List all medications or over the counter items you take:_____

List all topical medications or creams you use: _____

ALLERGIES to any medication or other allergies: _____

Medical services- Primary Insurance Policy :_____Policy # _____ Grp #_____
Claims tel#_____ Address (often listed on back of card) _____

Medical services- Secondary Insurance Policy :_____Policy # _____ Grp #_____
Claims tel#_____ Address (often listed on back of card) _____

Preferred Pharmacy Address:_____tel:_____fax:_____

I certify that the preceding statements are true and complete. I am aware that it is my responsibility to inform the doctor and all staff involved of my current medical or health conditions and to update this history. I am aware I am fiancially responsible for all charges by Company for services not paid by insurances if any, and or services not applicable to insurances.

Patient Name:_____Sign:_____Date:_____
Patient or legal representative

Reuben I Thaker MD PLLC dba Phaze Laser Med Spa, dba Thaker Cosmetic and Wellness

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. READ IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, his personnel, our office staff and others outside of our office, that are involved in your care and treatment, for the purpose of providing health care services to you, to pay your health care bills, to support operation of the physician practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose our protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred, to ensure that the physician has necessary information to diagnose and or treat you.

Payment: Your protected health information will be used, as needed to obtain payment for your health care services. For example, obtaining approval for a facility or hospital stay may require that your relevant protected health information be disclosed for the health plan approval for admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training personnel or medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to other personnel including physicians that see patients at our office or elsewhere, as needed for your medical care. In addition, we may use a sign-in sheet at a registration area where you sign your name and indicate your physician. We may also state your name among your care team, or in a waiting room when we are ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law; Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; for Coroners; for Funeral Directors; regarding Organ Donation; Research; Criminal Activity; Military Activity and National Security; Worker's Compensation; Inmates; Required Use and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures will be made only with your consent.

Authorization or Opportunity to Object unless required by law: you may revoke this authorization at any time in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information. You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of you protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want that restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by alternative means or location. You have the right to obtain a paper copy of this notice from us if you request. You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you in writing of any material charges. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us, or to Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our privacy contact, compliance officer, or your Provider, as applicable, by phone 702 545 0660 or mail 9420 W Sahara #105, Las Vegas, NV 89117. We will not retaliate against you for this. We will strive to correct the situation. Please state any objections or questions as to this form. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices regarding protected health information.

Signature below indicates that you have received this Notice of our Privacy Practices:

Patient Name:_____Sign:_____Date:_____
Patient or legal representative

Reuben I Thaker MD PLLC dba Phaze Laser Med Spa, dba Thaker Cosmetic and Wellness

Other Notices

No Emergency Services Provided
No emergency medical services are provided. If you have a medial emergency, call 911.

Scope of Medical Service [non cosmetic services]
Calls are answered during business hours [Tue-Fri 10am-6pm, and Sat 10am-6pm by appointment], within 1 business day or when possible. We may offer extended or weekend hours for patient visits at our discretion. Physician provides non-emergency medical services, outpatient only. For significantly debilitated and or medically complex patients, physician visits will generally be scheduled monthly, unless otherwise medically necessary. We will work in conjunction with your doctors as needed. For 'concierge' or episodic medical visit, we will provide a requested record of visit to your primary physician. We may advise services which are not performed by us, such as advanced tests such as MRI, consulting other specialist, or services outside the scope of our practice.

Cosmetic Services [non-medical services]
All sales final on all cosmetic services and packages. No guarantee of results has been implied or made. If you are receiving cosmetic services, such as esthetician, laser or other services, then you are receiving non- medical services without medical necessity. You do not have a doctor-patient relationship with our office nor any practitioner herein. Contact this office if regarding services performed by us, but contact your own physician for unrelated medical care otherwise. ALL LASER HAIR REMOVAL AND LASER TATTOO REMOVAL OR OTHER PACKAGES: Further, for safe, prompt and predictable results, and to respect scheduling of all clients, note the following policies: First session must be completed 30 days from purchase. Each session thereafter you must request and complete within 4-6wk. If you fail to complete a session as described, it is forfeit, whether you did not schedule, canceled, no show, or for any other reason. All of 6 sessions expire 6mo after your first session is due, all of 4 sessions expire 4mo after your first session due, and so forth. An easy way to remember this is that you are due for a session at 4-6 week intervals, and lose that service if you do not schedule and attend. A $50 reinstatement fee is due to continue services. We may reinstate the forfeit session if of comparable value. If in our sole judgment you can not complete a package due to unforseen circumstances, then we subtract used sessions at full retail value of 200% of discounted package value, from any refund if any.

Notice regarding records
You agree to keep a medication list with or on the person of you or your legal representative at all times, which you may provide to any other providers or entities related to your medical care. You agree to timely cooperate with us in obtaining records from any other providers or entities related to your medical care.

If you request, you may be provided with a patient website portal, to access your electronic medical record, accessible by you '24/7' through the internet. We are not responsible for maintaining this portal, providing internet access, nor monitoring your own use if you choose to access your records. You may request a copy of your records. $0.50/pg is due before copying, unless contravened by law.

Notice regarding medical director time [cosmetic or non-insurance covered services]
Medical director charges $150 per half hour of time or any fraction thereof for cosmetic consultation; for further time necessary to provide you services here; or for consultation with your medical providers or review of records or results; and if needed for bill collection or payment of any past or future services. You agree to such charges to your payment method on file without further notice.

Notice regarding appointment cancellation
We require 24 hour notice of any appointment cancellation. If this is not provided, you agree to a charge of $50 to your payment method on file without further notice. If the cosmetic service value is greater than $50, then you forfeit the service and no refund is due. For frequent cancellations, we require a $50 deposit for future appointments. You further agree that package sessions such as laser hair removal, are scheduled 5-6 weeks apart, and failure to complete the next session within 5-6 weeks, results in loss of the session or a $50 reinstate charge. Practice occasionally offers promotional free cosmetic, non-medical service. These expire 30 days from offer, are scheduled only once, and forfeited if canceled.

Signature indicates the undersigned has had opportunity to state objections or questions, and agrees to all notices.

Print patient name_____Sign:_____Date:_____
Patient or legal representative

Reuben I Thaker MD PLLC

RELEASE OF INFORMATION

ATTENTION HEALTH CARE ENTITY:

_____
_____
_____
_____

Please send all recent and pertinent medical records regarding the undersigned patient to Dr Thaker:

Reuben I Thaker MD PLLC
Reuben Thaker MD, NPI1 #1881890432
9420 W Sahara 105, LV NV 89117
tel 702 545 0660
fax 667 218 3074

This **RELEASE OF INFORMATION** remains in effect to the maximum extent allowable by law, until or unless canceled in writing by patient, and is applicable to receive health care information from any and all health care entities that Reuben I Thaker MD PLLC designates above at any time as appropriate and necessary for services rendered by Reuben I Thaker MD PLLC.

Print patient name_____DOB:_____Sign:_____Date:_____
Patient or legal representative

Reuben I Thaker MD PLLC

Advanced Beneficiary Notice-Medicare and or applicable insurances

Medicare does not pay for all services, even for example, for some services you or your physician deem medically necessary. This notice is given to you because it is known with reasonable certainty, that the services below are not Medicare-covered benefits. This means you are responsible for payment at the time of service. You will be charged only when the services are actually provided. The signature below is your request for these services, by you or the person responsible for your care.

Medicare and other insurances have rules which change and or may require interpretation. If a service is submitted for a coverage determination, and Medicare or insurance pays your physician, your payment may be refunded less co-pays or deductibles, upon notice to your physician.

☒ Further, I consent to telemedicine and or chronic care management services, which may not involve face to face encounters, and that these be performed without further notice and at physician discretion. Further, that these are subject to medicare or other insurance payment policies including patient responsibility. I may 'opt out' of such services by written 30 day notice to practice for any future such services beyond the notice period.

☐ Trip Fee:
Weekdays $25; Weekends $50
Out-of-Area Surcharge $25
waived in senior communities on scheduled visit days; waived if seeing multiple patients same residence;
otherwise specified _____.

☐ Other
Services:_____.
I want the 'other services' listed when applicable to my care. I will pay for them at the time of service.

I verify by my signature below that I am the patient or the patient's legal representative for the matters covered by this form, and I accept the provision/s checked above.

Print patient name_____DOB:_____Sign:_____Date:_____
Patient or legal representative